South Miami OPEN MRI

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APPOINTMENT: DATE: _____ **TIME:** _____

PATIENT NAME: _____ D.O.B. _____ M_____ F_____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: Home: _____ Cell: _____ Work: _____

PHYSICIAN NAME: _____ Ph#: _____ Fx #: _____

Office Address: _____ City: _____ State: _____ Zip: _____

PRIMARY INSURANCE: _____ Ph#: _____ Ext. _____

Policy No. _____ Claim No. _____ Adjuster: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURED'S NAME: _____ Relationship to Patient: . _____

SECONDARY INSURANCE: _____ Ph #: _____ Ext. _____

Policy No. _____ Group No. _____ Claim No. _____

DATE OF ACCIDENT: _____ ❑ Auto ❑ Worker's Comp. ❑ Slip & Fall ❑ Other: _____

ATTORNEY'S NAME: _____ Ph #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact: _____

MRI ❑ Without ❑ With & Without Contast

(All contrast studies----Lab work required)

Head
- ❑ Brain
- ❑ IAC's
- ❑ Orbit
- ❑ Pituitary
- ❑ Soft Tissue Neck

Body
- ❑ Adrenals
- ❑ Abdomen
- ❑ Pelvis
- ❑ Kidney
- ❑ Liver
- ❑ Pancreas
- ❑ Chest

Spine
- ❑ Cervical
- ❑ Thoracic
- ❑ Lumbar
- ❑ Sacrum
- ❑ Coccyx

Upper Extremities

❑ Shoulder	❑ L	❑ R
❑ Elbow	❑ L	❑ R
❑ Wrist	❑ L	❑ R
❑ Hand	❑ L	❑ R
❑ TMJ	❑ L	❑ R
❑ Long Bones	❑ L	❑ R

❑ Specify: _____

Lower Extremities

❑ Ankle	❑ L	❑ R
❑ Foot	❑ L	❑ R
❑ Knee	❑ L	❑ R
❑ Hip	❑ L	❑ R
❑ Long Bones	❑ L	❑ R

❑ Specify: _____

MRA ❑ Head ❑ Neck

X-RAYS GENERAL RADIOLOGY

❑ Cervical Spine	❑ Ankle	❑ L	❑ R
❑ Lumbar Spine	❑ Clavicle	❑ L	❑ R
❑ Thoracic Spine	❑ Elbow	❑ L	❑ R
❑ Sacrum	❑ Femur	❑ L	❑ R
❑ Coccyx	❑ Foot	❑ L	❑ R
❑ Bone Age	❑ Hand	❑ L	❑ R
❑ Chest	❑ Hip	❑ L	❑ R
❑ Facial Bones	❑ Humerus	❑ L	❑ R
❑ KUB	❑ Knee	❑ L	❑ R
❑ Nasal Bones	❑ Radius/Ulna	❑ L	❑ R
❑ Paranasal Sinuses	❑ Ribs	❑ L	❑ R
❑ Pelvis	❑ Shoulder	❑ L	❑ R
❑ Skull	❑ Tibia/Fibula	❑ L	❑ R
❑ Sternum	❑ Wrist	❑ L	❑ R

❑ Other: _____

ULTRASOUND ❑ WITH DOPPLER

- ❑ Abdomen Complete
- ❑ Abdomen Aorta
- ❑ Abdominal Wall
- ❑ Bladder
- ❑ Breast ❑ L ❑ R
- ❑ Gallbladder
- ❑ Head/Neck Soft Tissue
- ❑ Liver
- ❑ Pancreas
- ❑ Prostate (trans-abdominal)
- ❑ Pelvis
- ❑ Renal
- ❑ Renal & Bladder
- ❑ Soft Tissue
- ❑ Spleen
- ❑ Testicular
- ❑ Thyroid
- ❑ Trans vaginal
- ❑ Parathyroid

VASCULAR

❑ Arterial Upper Extremity	❑ L	❑ R
❑ Arterial Lower Extremity	❑ L	❑ R
❑ Venous Upper Extremity	❑ L	❑ R
❑ Venous Lower Extremity	❑ L	❑ R

❑ Carotid Doppler

❑ Others: _____

DIAGNOSIS: CODES (ICD 9/10) : _____ Treatment Starting Date: _____

Physician's Signature: _____ UPIN Number: _____

❑ Call for Stat **❑ CD Needed** **❑ Transportation**

IMPORTANT MEDICAL INFORMATION

If you have metallic implants, cardiac pacemaker, brain aneurysm clips, a history of being exposed to foreign metallic bodies in the eyes, or if you are (or may be) pregnant, PLEASE NOTIFY THE MEDICAL PERSONNEL PRIOR TO YOUR APPOINTMENT VERIFICATION.